BCD Health Partners

WYCKOFF PEDIATRICS

For COVID-19 vaccine recipients the following questions will help us determine if there is any reason COVID-19 vaccine cannot be given today. **If you answer "yes" to any question, it does not necessarily mean the vaccine cannot be given.** It just means Additional questions may be asked. If a question is not clear, please ask the healthcare provider to explain it.

Patient's Name: _____ Date of Birth: _____

	Yes	No	Don't Know
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Has the person to be vaccinated ever received a dose of COVID-19 vaccine?	☐	☐	☐

- If yes, which vaccine product was administered?

☐ Pfizer-BioNTech ☐ Johnson & Johnson ☐ Moderna

☐ Another product _____

- Did you bring the vaccination record card or other documentation today? ☐ ☐

3. Is the person to be vaccinated have a health condition or undergoing treatment that makes them moderately or severely immunocompromised? This would include, but not limited to, treatment for cancer, HIV, receipt of organ transplant, immunosuppressive therapy of high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant HCT, or moderate or severe primary immunodeficiency. ☐ ☐ ☐

4. Has the person to be vaccinated ever had an allergic reaction to: (This includes a severe allergic reaction that required treatment with Epipen or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing)

- A component of a COVID-19 vaccine	☐	☐	☐
- A previous dose of COVID-19 vaccine	☐	☐	☐

CONSENT FOR DEPENDENT'S VACCINATION AND RELEASE OF VACCINATION INFORMATION: I have read or had explained to me the information contained in the Emergency Use Authorization Fact Sheet for Recipients and Caregivers for the COVID-19 vaccine and understand the risks and benefits of the vaccine. I have had a chance to ask questions which have been answered to my satisfaction I understand the benefits and risks of the vaccine.

I authorize disclosure of this vaccination information to public health officials and other health care professionals. I understand that this vaccination will be recorded in the NJ State Immunization Information System (NJIIS) for the purposes of sharing vaccination information with other health care providers and tracking vaccine inventory.

Parent signature: _____ Date: _____

Patient signature if 18 years or older: _____ Date: _____